45th Day 11/17/11

PRINTED: 10/13/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	C 10/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #28747 and #28769, were completed on October 3, 2011, at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #28769 under 42 CFR PART 482.13, Requirements for Long Term Care. Deficiencies were cited on C/O #28747.	F 000	F157 **Corrective action for resident affected** included resident was sent to the ER for evaluation and was admitted on 09/19/2011. The family and Physician were notified by DON on 09/19/2011. DON obtained medication from the pharmacy on 09/19/2011 so that medication would be available for this resident upon readmission to the facility. 09/19/2011 started 100% licensed nursing staff in-service that was performed by the DON/ADON regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. In servicing was completed on 09/26/2011 with all nurses in-serviced prior to returning to facility. The two nurses involved were immediately suspended and were terminated on 9/23/2011. **All residents have the potential to be affected by this practice** All residents' medications were audited throughout the building on 09/19/2011 by the DON/ADON to ensure availability. No other medications where found to be unavailable. **Measures put into place to ensure deficient practice does not occur again are:** 100% of licensed nursing staff were in-serviced regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. All new licensed staff will be oriented as part of the orientation process starting on 09/20/2011. Pharmacy provided an additional in-service to licensed nursing staff on 09/21/2011. **The corrective actions will be monitored to ensure practice will not recur includes:** Medication availability audits for the entire building were performed starting daily on 09/19/2011 for 2 weeks by DON/ADON, and then will be performed weekly for two months, then monthly for two months. Any adverse results will be reported to the QA committee Results of this monitoring will be reported to the QA committee for analysis findings. Changes will be made to the action plan based on analysis. The QA committee consist of Administrator, DON, ADON, Nurse Educator, Activities director, Medical Director, Medical records, Dietary director, Environmental services, Social services, Maintenance, Rehab director, Admissions Coordinator.	09/26/2011 ~~10/4/11~~
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/24/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

10/26/11 4:00 pm Message left for Administrator re: completion date. Need.

10/27/11 11:40 AM Permission recd from Adm. Mark Miller to make completion date 10/4/11 on all F tags. Mary Ann Dyke RN

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility investigation review, and interview, the facility failed to notify pharmacy of the need for anti-seizure medications; failed to notify the physician anti-seizure medications were not available for the resident; and failed to notify the family the anti-seizure medications were unavailable for one (#3) of seven residents reviewed. The findings included: Resident #3 was admitted to the facility on September 17, 2011, with diagnoses including Seizures, Diabetes Mellitus, Hypertension, Coronary Artery Disease with Placement of Stents. Continued medical record review revealed the resident lived in an Assisted Living Facility; had been hospitalized due to aspiration pneumonia; and was transferred to the facility for rehabilitation. Medical record review of the Minimum Data Set dated September 6, 2011, revealed the resident had a BIMS (Brief Inventory of Mental Status) of 10 (15 being fully alert and oriented); required assistance with transfers, dressing, bathing, and grooming; was continent of bowel and bladder; was independent with eating; used a walker or wheelchair for mobility.	F 157		

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F 157	Continued From page 2 Medical record review of nursing notes dated September 19, 2011, revealed the resident was in the front lobby in the wheelchair when...had a seizure. Continued medical record review revealed the resident was non-responsive after the seizure and was placed on the resident's side on the floor. Further medical record review revealed the resident suffered a second seizure after which the resident required suctioning. Continued medical record review revealed the resident suffered a third seizure before being transferred to the hospital. Medical record review of the Emergency Department record revealed patient had "grand mal seizure due to not receiving Lamictal for 48 hours. Patient had history of seizures 3-4 years. Breakthrough seizures if.. does not receive medications." Medical record review of physician's admission orders dated August 17, 2011, revealed the resident was ordered Lacosamide (Lamictal) 100 mg (milligrams) every 12 hours for seizures. Medical record review of the Medication Administration Record (MAR) revealed the resident received the Lamictal on September 17, 2011, at 7:51 p.m. Continued medical record review of the MAR revealed the medication was not administered on September 18, 2011, at 8:00 a.m., or 8:00 p.m., nor was it administered on September 19, 2011, at 8:00 a.m. Review of documentation dated September 18, 2011, revealed the nurse sent an email to the pharmacy requesting the medication, but failed to notify the backup pharmacy by telephone to get	F 157		

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F 157	Continued From page 3 the medication called into the pharmacy. Further review of documentation dated September 18, 2011, revealed the evening nurse charted the medication was "held due to waiting available from pharmacy." Continued review of documentation dated September 19, 2011, revealed the nurse sent an email to the pharmacy requesting the medication and then called pharmacy later in the morning who stated they would call the nurse when the medication was in the back-up pharmacy. Review of the pharmacy policy revealed "Enter order into E-Mar (electronic MAR) and send to pharmacy. Call on-Call pharmacy and leave message of order needed. On Call pharmacist will call back and arrange for medication to be obtained from back-up pharmacy and arrange delivery." Review of the facility investigation revealed on September 17, 2011, the nurse failed to notify pharmacy there was no more Lamictal for the resident. Continued review revealed the nurse on September 18, 2011, notified pharmacy by email the medication was not available but failed to notify the backup pharmacy by telephone to get the medication to the pharmacy. Further review revealed on September 18, 2011, the evening nurse failed to give the medication because there was none to give and also failed to notify pharmacy and follow the protocol. Review of a facility interview with Nurse #1 dated September 20, 2011, revealed the employee "...did not call backup pharmacy on September 18, 2011, to obtain medication for resident on...assigned hall. This resident missed a dose of	F 157		

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F 157	Continued From page 4 anti-seizure medication during this employee's shift. Family was not notified; physician was not notified; pharmacy was not notified by phone. This employee is suspended pending investigation at this time." Review of a facility interview with Nurse #2 on September 23, 2011, revealed "This employee did not attempt to obtain medication from pharmacy on September 18, 2011. Family was not notified nor was the physician." Continued review of facility investigation revealed both employees were terminated. Review of facility policy, Medication Administration, revealed "The Director of Nursing and resident's attending physician will be notified when three (3) consecutive doses of a medication are refused or withheld. With medications such as Cardiac, Anticonvulsants, and/or Diabetic drugs with one missed dose, the physician is to be notified. The reporting nurse will chart this notification in the nurses' notes in the resident's medical record." During interview on October 4, 2011, at 3:30 p.m., in the conference room, the Director of Nursing confirmed the nurse failed to follow correct procedures and failed to notify the pharmacy correctly the medications were not available; filed to notify the physician the medication had not been administered for three doses; and failed to notify the family the resident had not received three doses of medication.	F 157		
F 281	C/O #28747 483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 5 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility investigation review, and interview, the facility failed to meet professional standards in providing care to a resident by failing to obtain anti-seizure medications and failing to administer anti-seizure medications to one (#3) of seven residents reviewed. The findings included: Resident #3 was admitted to the facility on September 17, 2011, with diagnoses including Seizures, Diabetes Mellitus, Hypertension, Coronary Artery Disease with Placement of Stents. Continued medical record review revealed the resident lived in an Assisted Living Facility; had been hospitalized due to aspiration pneumonia; and was transferred to the facility for rehabilitation. Medical record review of the Minimum Data Set dated September 6, 2011, revealed the resident had a BIMS (Brief Inventory of Mental Status) of 10 (15 being fully alert and oriented); required assistance with transfers, dressing, bathing, and grooming; was continent of bowel and bladder; was independent with eating; used a walker or wheelchair for mobility.	F 281	**F281** **Corrective action for resident affected** included resident was sent to the ER for evaluation and was admitted on 09/19/2011. The family and Physician were notified by DON on 09/19/2011. DON obtained medication from the pharmacy on 09/19/2011 so that medication would be available for this resident upon readmission to the facility. 09/19/2011 started 100% licensed nursing staff in-service that was performed by the DON/ADON regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. In servicing was completed on 09/26/2011 with all nurses in-serviced prior to returning to facility. The two nurses involved were immediately suspended and were terminated on 9/23/2011. **All residents have the potential to be affected by this practice** All residents' medications were audited throughout the building on 09/19/2011 by the DON/ADON to ensure availability. No other medications where found to be unavailable. **Measures put into place to ensure deficient practice does not occur again are:** 100% of licensed nursing staff were in-serviced regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. All new licensed staff will be oriented as part of the orientation process starting on 09/20/2011. Pharmacy provided an additional in-service to licensed nursing staff on 09/21/2011. **The corrective actions will be monitored to ensure practice will not recur includes:** Medication availability audits for the entire building were performed starting daily on 09/19/2011 for 2 weeks by DON/ADON, and then will be performed weekly for two months, then monthly for two months. Any adverse results will be reported to the QA committee Results of this monitoring will be reported to the QA committee for analysis findings. Changes will be made to the action plan based on analysis. The QA committee consist of Administrator, DON, ADON, Nurse Educator, Activities director, Medical Director, Medical records, Dietary director, Environmental services, Social services, Maintenance, Rehab director, Admissions Coordinator.	09/26/2011 10/4/11

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F 281	Continued From page 6 Medical record review of nursing notes dated September 19, 2011, revealed the resident was in the front lobby in the wheelchair when...had a seizure. Continued medical record review revealed the resident was non-responsive after the seizure and was placed on the resident's side on the floor. Further medical record review revealed the resident suffered a second seizure after which the resident required suctioning. Continued medical record review revealed the resident suffered a third seizure before being transferred to the hospital. Medical record review of the Emergency Department record revealed patient had "grand mal seizure due to not receiving Lamictal for 48 hours. Patient had history of seizures 3-4 years. Breakthrough seizures if.. does not receive medications." Medical record review of physician's admission orders dated August 17, 2011, revealed the resident was ordered Lacosamide (Lamictal) 100 mg (milligrams) every 12 hours for seizures. Medical record review of the Medication Administration Record (MAR) revealed the resident received the Lamictal on September 17, 2011, at 7:51 p.m. Continued medical record review of the MAR revealed the medication was not administered on September 18, 2011, at 8:00 a.m., or 8:00 p.m., nor was it administered on September 19, 2011, at 8:00 a.m. Review of documentation dated September 18, 2011, revealed the nurse sent an email to the pharmacy requesting the medication, but failed to notify the backup pharmacy by telephone to get	F 281		

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F 281	Continued From page 7 the medication called into the pharmacy. Further review of documentation dated September 18, 2011, revealed the evening nurse charted the medication was "held due to waiting available from pharmacy." Continued review of documentation dated September 19, 2011, revealed the nurse sent an email to the pharmacy requesting the medication and then called pharmacy later in the morning who stated they would call the nurse when the medication was in the back-up pharmacy. Review of the pharmacy policy revealed "Enter order into E-Mar (electronic MAR) and send to pharmacy. Call on-Call pharmacy and leave message of order needed. On Call pharmacist will call back and arrange for medication to be obtained from back-up pharmacy and arrange delivery." Review of the facility investigation revealed on September 17, 2011, the nurse failed to notify pharmacy there was no more Lamictal for the resident. Continued review revealed the nurse on September 18, 2011, notified pharmacy by email the medication was not available but failed to notify the backup pharmacy by telephone to get the medication to the pharmacy. Further review revealed on September 18, 2011, the evening nurse failed to give the medication because there was none to give and also failed to notify pharmacy and follow the protocol. Review of a facility interview with Nurse #1 dated September 20, 2011, revealed the employee "...did not call backup pharmacy on September 18, 2011, to obtain medication for resident on...assigned hall. This resident missed a dose of	F 281		

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F 281	Continued From page 8 anti-seizure medication during this employee's shift. Family was not notified; physician was not notified; pharmacy was not notified by phone. This employee is suspended pending investigation at this time." Review of a facility interview with Nurse #2 on September 23, 2011, revealed "This employee did not attempt to obtain medication from pharmacy on September 18, 2011. Family was not notified nor was the physician." Continued review of facility investigation revealed both employees were terminated. Review of facility policy, Medication Administration, revealed "The Director of Nursing and resident's attending physician will be notified when three (3) consecutive doses of a medication are refused or withheld. With medications such as Cardiac, Anticonvulsants, and/or Diabetic drugs with one missed dose, the physician is to be notified. The reporting nurse will chart this notification in the nurses' notes in the resident's medical record." During interview at 2:30 p.m., on October 4, 2011, in the conference room, the Director of Nursing confirmed the nurse failed to obtain necessary anti-seizure medications from pharmacy and failed to administer anti-seizure medications as ordered by the physician. C/O #28747	F 281		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		

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F 333	Continued From page 9 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility investigation review, and interview, the facility failed to obtain anti-seizure medications and failed to administer anti-seizure medication for one (#3) of seven residents reviewed. The findings included: Resident #3 was admitted to the facility on September 17, 2011, with diagnoses including Seizures, Diabetes Mellitus, Hypertension, Coronary Artery Disease with Placement of Stents. Continued medical record review revealed the resident lived in an Assisted Living Facility; had been hospitalized due to aspiration pneumonia; and was transferred to the facility for rehabilitation. Medical record review of the Minimum Data Set dated September 6, 2011, revealed the resident had a BIMS (Brief Inventory of Mental Status) of 10 (15 being fully alert and oriented); required assistance with transfers, dressing, bathing, and grooming; was continent of bowel and bladder; was independent with eating; used a walker or wheelchair for mobility. Medical record review of nursing notes dated September 19, 2011, revealed the resident was in the front lobby in the wheelchair when...had a seizure. Continued medical record review revealed the resident was non-responsive after	F 333	F333 **Corrective action for resident affected** included resident was sent to the ER for evaluation and was admitted on 09/19/2011. The family and Physician were notified by DON on 09/19/2011. DON obtained medication from the pharmacy on 09/19/2011 so that medication would be available for this resident upon readmission to the facility. 09/19/2011 started 100% licensed nursing staff in-service that was performed by the DON/ADON regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. In servicing was completed on 09/26/2011 with all nurses in-serviced prior to returning to facility. The two nurses involved were immediately suspended and were terminated on 9/23/2011. **All residents have the potential to be affected by this practice** All residents' medications were audited throughout the building on 09/19/2011 by the DON/ADON to ensure availability. No other medications where found to be unavailable. **Measures put into place to ensure deficient practice does not occur again are:** 100% of licensed nursing staff were in-serviced regarding pharmacy policy and procedure, medication administration, and notification of family and physician notification. All new licensed staff will be oriented as part of the orientation process starting on 09/20/2011. Pharmacy provided an additional in-service to licensed nursing staff on 09/21/2011. **The corrective actions will be monitored to ensure practice will not recur includes:** Medication availability audits for the entire building were performed starting daily on 09/19/2011 for 2 weeks by DON/ADON, and then will be performed weekly for two months, then monthly for two months. Any adverse results will be reported to the QA committee Results of this monitoring will be reported to the QA committee for analysis findings. Changes will be made to the action plan based on analysis. The QA committee consist of Administrator, DON, ADON, Nurse Educator, Activities director, Medical Director, Medical records, Dietary director, Environmental services, Social services, Maintenance, Rehab director, Admissions Coordinator.	09/26/2011 10/4/11

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F 333	Continued From page 10	F 333		

the seizure and was placed on the resident's side on the floor. Further medical record review revealed the resident suffered a second seizure after which the resident required suctioning. Continued medical record review revealed the resident suffered a third seizure before being transferred to the hospital.

Medical record review of the Emergency Department record revealed patient had "grand mal seizure due to not receiving Lamictal for 48 hours. Patient had history of seizures 3-4 years. Breakthrough seizures if., does not receive medications."

Medical record review of physician's admission orders dated August 17, 2011, revealed the resident was ordered Lacosamide (Lamictal) 100 mg (milligrams) every 12 hours for seizures.

Medical record review of the Medication Administration Record (MAR) revealed the resident received the Lamictal on September 17, 2011, at 7:51 p.m. Continued medical record review of the MAR revealed the medication was not administered on September 18, 2011, at 8:00 a.m., or 8:00 p.m., nor was it administered on September 19, 2011, at 8:00 a.m.

Review of documentation dated September 18, 2011, revealed the nurse sent an email to the pharmacy requesting the medication, but failed to notify the backup pharmacy by telephone to get the medication called into the pharmacy. Further review of documentation dated September 18, 2011, revealed the evening nurse charted the medication was "held due to waiting available from pharmacy." Continued review of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 11 documentation dated September 19, 2011, revealed the nurse sent an email to the pharmacy requesting the medication and then called pharmacy later in the morning who stated they would call the nurse when the medication was in the back-up pharmacy. Review of the pharmacy policy revealed "Enter order into E-Mar (electronic MAR) and send to pharmacy. Call on-Call pharmacy and leave message of order needed. On Call pharmacist will call back and arrange for medication to be obtained from back-up pharmacy and arrange delivery." Review of the facility investigation revealed on September 17, 2011, the nurse failed to notify pharmacy there was no more Lamictal for the resident. Continued review revealed the nurse on September 18, 2011, notified pharmacy by email the medication was not available but failed to notify the backup pharmacy by telephone to get the medication to the pharmacy. Further review revealed on September 18, 2011, the evening nurse failed to give the medication because there was none to give and also failed to notify pharmacy and follow the protocol. Review of a facility interview with Nurse #1 dated September 20, 2011, revealed the employee "...did not call backup pharmacy on September 18, 2011, to obtain medication for resident on...assigned hall. This resident missed a dose of anti-seizure medication during this employee's shift. Family was not notified; physician was not notified; pharmacy was not notified by phone. This employee is suspended pending investigation at this time."	F 333		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445391	A. BUILDING _____ B. WING _____	C 10/03/2011

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F 333	Continued From page 12 Review of a facility interview with Nurse #2 on September 23, 2011, revealed "This employee did not attempt to obtain medication from pharmacy on September 18, 2011. Family was not notified nor was the physician." Continued review of facility investigation revealed both employees were terminated. Review of facility policy, Medication Administration, revealed "The Director of Nursing and resident's attending physician will be notified when three (3) consecutive doses of a medication are refused or withheld. With medications such as Cardiac, Anticonvulsants, and/or Diabetic drugs with one missed dose, the physician is to be notified. The reporting nurse will chart this notification in the nurses' notes in the resident's medical record." During interview on October 4, 2011, at 2:30 p.m., in the conference room, the Director of Nursing confirmed the nurses failed to obtain anti-seizure medications from the pharmacy per policy and also filed to administer anti-seizure medications which were ordered by the physician. C/O #28747	F 333		